U.S. Army Training Base Attrition -- Army Training and Doctrine Command and Army Medical Command Medically-Related Initial Entry Training Separations Review Program

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Agenda

- Definitions
- History and purpose of the TRADOC/ MEDCOM medically-related IET separations review program
- TRADOC Review and Initiatives
- MEDCOM Review and Initiatives
- TRADOC and MEDCOM Way Ahead
- Possible Retention Initiatives
- Breaking News

Definitions

- ELS – Entry Level Separation; a non-medical, administrative category of Soldier elimination during their first six months of service
  - Failure to Adapt
  - Unable to qualify on M16
  - Unable to pass the PT test
  - others
- Chapter 5-11, EPTS Separation – Existed Prior to Service – a medical condition that existed prior to a Soldier entering active duty
- Chapter 5-17, Other Medical – a catch-all category for conditions that are not conducive to a civilian becoming a deployable Warrior
  - Enuresis
  - Sleep-walking

Previous IET Attrition Research: "What We Think We Know"

- **Currently collected demographics have minimal value in predicting Soldier's individual attrition risk**
- **Multiple reasons why a Soldier actually attrits, but management information systems capture only one reason (AAA, ARI)**
- **Attrition categories are fungible & statistics not exact (AMSARA, AAA, ARI)**
- **Significant overlap between EPTS & Other Medical categories (AMSARA)**
- **Minimal overlap between medical & ELS administrative categories (AMSARA)**
- **EPTS & ELS-FTA discharge rate increasing (data)**
- **Recruits & Army trainers "venue shop" for most expeditious discharge (ARI)**
- **Few recruits attrit for BRM failure, end of course training failure, Army physical fitness test failure (data)**
- **Large differences in attrition rates between Army Training Centers even after controlling for Soldier demographics (RAND)**
- **Soldiers with higher initial fitness levels less likely to attrit (CHPPM and RAND)**
- **Increased IET attrition does not necessarily reduce subsequent unit attrition (RAND)**

What are the Three Medically-Related IET Separations?

- EPTS – Existed Prior to entering Service (Chapter 5-11)
  - Medical community must verify pre-existence of a disqualifying condition IAW Chap 2, AR 40-501
- Entry Level Separation (ELS)-Failure to Adapt
  - Behavioral Health community must ensure psychiatric disease is not the cause of the “failure to adapt”
- Other Medical (Chapter 5-17)
  - Medical community must verify a medical condition that is preventing the Soldier from meeting standards

The Numbers (BCT/OSUT)

(12 month rolling data from ATRRS)

Feb 05		May 05
4599 (45.1%)	EPTS	4474 (45.7%)
3318 (32.6%)	ELS-FTA	3131 (32.0%)
713 (7.0%)	Other Med	728 (7.4%)
8630 (84.7%)	Sub-Total (Medically-Related Seps)	8333 (85.1%)
10,188	Total D/Cs (All Categories)	9780
73.4K	RecBn Inputs	64.9K
13.9%	Overall Attrition Rate	15.1%

Top 4 Discharge Reasons by ATC

for 12 Month Period Ending 31 May 05

	1st	2nd	3rd	4th
Ft Benning	EPTS	ELS - Failure to Adapt	Homosexual Conduct	Other Medical
	51.2%	39.4%	3.6%	2.2%
Ft Jackson	ELS - Failure to Adapt	EPTS	Other Medical	COG
	49.1%	40.0%	3.9%	1.8%
Ft Knox	EPTS	Other Medical	ELS - Failure to Adapt	Misconduct
	41.6%	38.3%	13.4%	2.7%
Ft Leonard Wood	EPTS	ELS - Failure to Adapt	Other Medical	ELS - LOM
	52.0%	22.2%	6.3%	5.9%
Ft Sill	EPTS	COG	ELS - Failure to Adapt	ELS - APFT
	37.2%	26.7%	15.1%	10.5%

TRADOC/MEDCOM Medically-Related IET Separation Review Program

- **CG TRADOC requested Commanders "take a look at IET attrition"**
  - **IET Bde Commanders Conference Feb 05**
  - **IMT Commandants Conference Mar 05**

- **TRADOC DCG-IMT/Cdr, USAAC, issued guidance to BCT/OSUT Commandants and USAMEDCOM early Apr 05**
  - **Develop a HQ-level, medically-related, IET administrative separation tracking, review, and analysis program for TRADOC and MEDCOM**
  - **Have Commandants' Senior Chaplain and IG review and analyze how medically-related admin separation categories are used by training units and by their supporting MEDDACs**
  - **Review and analyze whether medical and training leaders could/ should identify low risk Soldiers who could benefit from simple, short-term medical/support interventions, then allow treatment to occur in an effort to decrease attrition**
  - **Review/establish best screening and intervention practices for medically related IET administrative separations**

Commandants Internal Review Questions

- What is the training unit philosophy regarding attrition and graduation rates?
- Which medically related IET administrative separation is preferentially used at the installation and why?
- Is there an effort to identify reversible problems that, if corrected, could result in decreased attrition? If yes, are units consulting with appropriate agencies/clinics to obtain appropriate interventions for their IET Soldiers?
- Are IET Soldiers. who have been identified for admin separation, given the opportunity for a fresh start in a different training unit (when appropriate)?
- What is the role of DS, 1SG, Co Cdr, Bn CSM, and Bn Cdr in admin separations?
- What is the role of the unit ministry team in Soldiers with ideations of self-harm?

Commandant Review Findings -- 1

- **There was minimal emphasis on attrition prior to Apr 05**
- **Type of Separation depends more on the installation than the actual medical condition**
- **RecBn MMOT needs revision to only capture life-threatening and medically resource-intensive DXs**
- **There is minimal if any attempt to identify correctable conditions (by trainers or medical personnel)**
- **Several BH clinics use “boiler-plate” templates for recommending separations (and almost never recommend retention)**
- **Unit leaders unwilling to assume risk if medical providers recommend separation for medical or behavioral conditions**
- **Need better communication between Co Cdrs/1SGs and medical professionals (vs. informing the Soldier about separation recommendations)**

Commandant Review Findings -- 2

- **Far Forward Care (physical therapy, behavioral health, and unit level sick call) and Self-Care are force multipliers**
- **IET Training Philosophy and Investment Strategy not fully understood by DSs, Cadre, Unit Leaders or medical community**
- **Role of Drill Sergeants, 1SGs, and Co Cdrs in the Separation process varies by installation**
- **Unit Ministry Teams are a force multiplier – 100% fill should be the standard in training units**
- **UMTs need ASIST training and special training in para-suicidal behavior**
- **Fresh Start/Second Chance Programs can result in salvaging challenging Soldiers**

MEDCOM Internal Review Questions

- **Do EPTS admin separations require “proof” of pre-existence (clinical records? formal parental/legal guardian statements of pre-existence? Telephonic confirmation with primary care providers? etc.)?**

- **How do Medical, Orthopedics, Physical Therapy, and Behavioral Health professionals evaluate, verify, and process Soldiers with EPTS conditions? How do they evaluate, verify, and process soldiers categorized as “ELA-Failure to Adapt” or Chapter 5-17 “Other Medical” separations?**

- **Are Behavioral Health, Medical, Orthopedic, and Physical Therapy personnel identifying low to low-moderate risk Soldiers who can be encouraged/supported to continue training (to standard)? If yes, do medical personnel make recommendations for therapy/interventions to training unit personnel? If yes, are these interventions being offered to and used by IET Soldiers?**

- **Would “far-forward” care by Physical Therapy and Mental Health personnel decrease attrition through earlier interventions?**

MEDCOM Findings: Recruits

- Widespread perception of decreased recruit “quality”
  - Seasonal variance in recruit demographics
- Recruits and drill sergeants know they are going to war
  - Are recruits being treated like they are going to war?
- Interviews with “failed Soldiers” question training environment
  - Humiliation described by soldiers being administratively separated
  - Also described by NCOs
- New Program of Instruction mandates earlier weapons immersion and wearing of Individual Body Armor during training
  - Increased stress fractures in men and women (numbers?)
  - Injured Soldiers lose motivation during convalescence

MEDCOM Findings: EPTS Issues

- Most attrition occurs in first few weeks (red phase)
- Some recruits relapse off their psychiatric medications (anecdotal information)
  - Depression, ADHD
- Local physicians not seeking waivers if recruit has disqualifying diagnosis but can serve
- Prior medical records may be aid to disposition
- EPTS diagnosis may or may not predict success/failure at IET

MEDCOM Findings: Suicidal Behavior

- Recruit suicide gestures/threats common (actual suicides very rare)
- Suicidal behavior leads to separation
- Hospitalization automatic route to separation
- Actual risk of completed suicide is low since almost all gestures/threats have secondary gain intent
- Contagion of suicide threats and “going home” advice from other Soldiers a major disruption
- Drill sergeants do not receive training in DSS on dealing with recruits with disruptive or suicidal behavior
  - ASIST training conducted, but does not address this knowledge deficit
- Behavioral health providers a “rubber stamp” in recommending separation to minimize risk for disruptive or suicidal behaviors

MEDCOM Findings: Command – Behavioral Health Interface

- Inconsistent communication between behavioral health, medical, chaplains, and Command
- Inconsistent referral process to behavioral health by physicians, chaplains, and Command
- Medical personnel do not yet understand the importance of retention
- Commanders often see behavioral health as “ticket home” for recruit
  - Do not see Behavioral Health as a resource to help retain Soldiers
  - Separation recommendations often made without input from commanders or trainers

MEDCOM Findings: Intervention

- UMT personnel and trainers key in reducing attrition
- Forward deployed staff more effective
  - Recruits do not have to leave training environment
  - Recruits maintain a Soldier “mentality”
- Early intervention not consistent at five BCT MTFs
- Behavioral health is not oriented towards treatment or rehabilitation
- Momentum to go home raises with behavioral health contact (take on a “patient” mentality)
- “Second Chance” and “Recruit Re-Start” programs have come and gone
  - Success metrics have not been kept
- Variable effort to address recruit motivation by trainers or medical personnel

MEDCOM Findings: Injuries

- #1 injury of concern is stress fracture (4:1 Female to Male)
  - No standardized rehabilitation or training programs for those diagnosed with stress fracture
  - Injury rates have increased with increased rigor
- Physical Therapist “forward” works, but has pros and cons
- Physical Training Rehabilitation Program (PTRP)
  - 50-65 % return to BCT
  - Of those who return, similar graduation/ attrition rates
  - Leadership issue - how to keep injured Soldiers motivated?
- New combat boots heavy (and perhaps an injury issue)
  - Drill Sergeants prefer not wearing the new boots
- Gender differences in injury
  - Ft. Jackson appears to have very high injury rate in females
  - Pelvic stress fractures from road marches, increased load

MEDCOM Findings: Injury Prevention

- Drill sergeants not adequately trained in injury prevention (receive only PT-related injury prevention training at the DSS)
  - Compare to athletic trainers used by West Point, Marines
- Trainers and leaders need renewed interest/ emphasis in injury prevention
- No uniform surveillance between sites (CHPPM)
  - Need “real time” injury surveillance data
- Medical staff do not have adequate resources to observe training, make recommended changes to individual and collective methodologies

MEDCOM Findings: Motivational Factors

- High motivation decreases risk of attrition
- Factors that can increase performance
  - Success
  - Confidence
  - Group cohesion
  - Sense of purpose
- Motivation to train is a psychological process
- Unpleasant experiences can serve as toxins that diminish motivation to train or continue the mission
- Challenge: can recruits be trained to effectively persevere in the face of motivational toxins?

  (Homesickness, Separation from Romantic Partner, Anxiety / Fear, Lack of Privacy, Lack of Sleep, Sense of Failure, Physical Discomfort, Ostracism / Rejection, Intimidation, Injury, Failure to Connect with Battle Buddy or Others, Recycling)

First IPR Conducted 27 July 05

TSG and TRADOC DCG-IMT in attendance; senior AAC/TRADOC and OTSG staff presented internal reviews findings and way ahead; TSG and DCG-IMT agreed with findings and made commitment to the way ahead

TRADOC Way Ahead - 1

- **Inculcate the TRADOC Training Philosophy and Investment Strategy in all IET leaders and DSs (DCG-IMT, AAC CSM, TRADOC Leaders)**

- **Ensure the supporting medical community understands and supports the TRADOC Training Philosophy and Investment Strategy (TSG, OTSG Staff, and AMEDD Leaders)**

- **Commandants implement IET retention improvements (Tool Bag). DCG-IMT hosts a quarterly VTC with the five ATC Commandants to discuss increasing retention**
  (next VTC 29 July).

- **Develop and implement Success Metrics (TRADOC and AAC Staff)**
  - **RecBn Attrition Goal (1% or less)**
  - **TRADOC Graduation Goal of 90% or more (initial)**
  - **Tracking recruiting mission with linkage to IET graduation**
  - **Fresh Start/Second Chance program**

- **Update Medical Moment of Truth (Surgeon and OTSG)**
  - **ID only life threatening or resource intensive conditions for separation, otherwise clear for training and allow “trail of duty”**
  - **Allow MEDCOM Personnel to brief the MMOT in the RecBn**

- **Expand UMT training and increase IET involvement (Surgeon and OTSG)**

TRADOC Way Ahead - 2

- **Do not allow EPTS Separation for waivered conditions unless they are quantifiably worse. Will requires verification by MEDDAC personnel (Surg)**
- **Improve DS/1SG/CoCdr and Bn CSM/BN Cdr/Bde CSM/Bde Cdr Knowledge on Gen Y, Injury prevention (Surgeon, DSSs)**
- **Renew emphasis on injury prevention (Surgeon, DCG-IMT)**
- **Develop a standardized PTRP "POI" (Surgeon, AAC Staff, PTRP Commanders, MEDDAC Physical Therapists)**
- **Code all five (5) PTRP Co Cdr positions for Physical Therapists (Surgeon -- done)**
- **Foster and encourage a credible TRADOC-MEDCOM Partnership**
  - **Support Soldiers to Success**
  - **ID of correctable conditions that can be treated (with treatment and rehab supported by TRADOC)**
  - **Open communication between Docs and Cdrs**
- **Incorporate seasoned MEDCOM Psychologist into the TRADOC Surgeon Staff for two year assignment (Surgeon and OTSG)**

MEDCOM/OTSG Way Ahead -- 1

- MEDCOM/OTSG publish guidelines for BCT Medical Treatment Facility (MTF) staffs to
  - Improve classification of all medically related administrative separations (i.e., eliminates confusion over 5-17s vs. EPTS)
  - Standardize verification of EPTS conditions
  - Obtain input from commands / drill sergeants to verify Recruit performance prior to determining disposition
  - TRADOC mirrors this guidance for Co/Bn Commanders
- MTF leaders to expand role of staff to include rehabilitation oriented processes

MEDCOM/OTSG Way Ahead -- 2

- MTFs to add “retention” as option to entrance physical examination boards (the “board” that decides EPTS Administrative Separations)
- MTFs/UMTs to incorporate stress inoculation training at Reception Battalions
- Standardize Medical Moment of Truth Briefing so that it only identifies life-threatening and/or resource intensive conditions
  - All other EPTS conditions given trail of duty
  - MTF staff presents MMOT Briefing at Reception Battalions

MEDCOM/OTSG Way Ahead -- 3

- Help MTFs identify resource requirements that will allow
  - positioning of behavioral health personnel in training areas to keep recruits in training environment
  - robust Physical Therapist involvement in PTRP
  - provision of sick call screening for IET Soldiers in order to reduce time away from training and negative impact of lost training time, sick or injured “contagions”
- Develop training for MTF staff on retention of Soldiers
- MEDCOM assign senior active duty clinical psychologist to TRADOC Surgeon’s office for 2-yr. special duty and evaluate for future positioning

TRADOC-MEDCOM Medically-Related IET Separations Executive IPRs will be conducted quarterly to review progress in implementing way ahead recommendations and progress in reducing IET attrition

Possible Retention Initiatives

- Allowing IET Soldiers to receive standardized “Permanent” Medical Profiles (P2 max) with alternate Physical Fitness testing events
  - would have “expiration” date annotated in order to require a reassessment in 6-24 months
  - would increase graduation rates, decrease EPTS separations
- Recruiting “overweight for height” Soldiers, even if they do not meet AR 40-501 Body Fat standards

Breaking News

- **The Chief of Staff of the Army (CSA) directed that the DA Inspector General “inspect” First Term attrition (IET through the first 36 months of active duty)**
- **Inspection began 1 August 2005 at Fort Monroe; will be visiting both TRADOC and FORSCOM units**
- **Inspection completion and reporting to CSA NLT 15 October 2005**

Questions? Comments? Concerns?